JANUARY 2021 HIGHLIGHTS

Investigations Involving Health Care

Former Chief of Pathology at the Veterans Health Care System of the Ozarks in Fayetteville, Arkansas, Sentenced for Involuntary Manslaughter and Mail Fraud

A former chief of pathology was sentenced to 20 years' incarceration, three years' probation, and approximately $497,000 in restitution after pleading guilty to involuntary manslaughter and mail fraud. The VA OIG investigation revealed the defendant misdiagnosed thousands of VA patients while under the influence of a potent substance that causes a lengthy intoxication period, but no hangover, and is undetectable using routine drug and alcohol testing methods. The defendant also circumvented contractually obligated drug and alcohol testing to conceal his chemical dependency.

Former Doctor at the Beckley VA Medical Center in West Virginia Sentenced for Civil Rights Offense

A former doctor specializing in osteopathic manipulation therapy was sentenced to 25 years' incarceration and three years' probation after pleading guilty to the deprivation of rights under the color of law (civil rights). A VA OIG, Federal Bureau of Investigation (FBI), and VA Police Service investigation revealed that the defendant sexually abused three patients who sought chronic pain treatment during examinations at the facility.

Contractor Agrees to Pay $179.7 Million to Resolve Overpayment Claims

A contractor responsible for administering VA's Patient-Centered Community Care and Veterans Choice programs entered into a settlement agreement with the Department of Justice Civil Division's Commercial Litigation Branch and the U.S. Attorney's Office for the District of Arizona to resolve allegations that it retained overpayments received from VA. The two programs enabled veterans to obtain medical care from private sector providers in their communities. As an administrator of these programs, the contractor was paid by VA to coordinate medical appointments and make payments to community healthcare providers. The alleged overpayments included duplicate payments VA made to the contractor for the same services as well as payments for services for which the contractor received full or partial reimbursement. Pursuant to the settlement agreement, the contractor will pay $179.7 million to the government. Of this amount, VA will receive approximately $158 million.

Owner of Wholesale Pharmaceutical Company Charged in Scheme to Hoard Personal Protective Equipment and Price Gouge Healthcare Providers

The owner of a wholesale pharmaceutical company was indicted in the Southern District of Mississippi on charges of conspiracy to commit wire fraud and mail fraud, conspiracy to defraud the United States, conspiracy to commit hoarding of designated scarce materials, and hoarding of designated scarce materials. A VA OIG, U.S. Immigration and Customs Enforcement's Homeland Security Investigations, and FBI investigation resulted in charges alleging that the defendant participated in a scheme to defraud

healthcare providers, to include VA, of more than $1.8 million by acquiring and hoarding personal protective equipment. It is alleged that the defendant directed sales representatives to solicit healthcare providers, including VA, to purchase personal protective equipment and other designated materials at excessively inflated prices through high-pressure sales tactics and through misrepresenting sourcing and actual costs. The defendant allegedly sold N95 masks to VA and other healthcare providers for as much as $25 per mask, despite acquiring such masks at much lower prices. The total amount of designated scarce materials billed to VA by the vendor was approximately $334,300.

Former Employee at the VA Puget Sound Healthcare System in Seattle, Washington, Sentenced for Theft of Government Property

A terminated employee was sentenced to three months' incarceration, nine months' home confinement with electronic monitoring, and three years' supervised release after pleading guilty to theft of government property. The defendant was also ordered to pay restitution to VA in the amount of $132,291. A VA OIG investigation revealed that the defendant stole several pieces of medical equipment, to include ventilators and bronchoscopes, and then sold the stolen items online.

Two Defendants Plead Guilty to Conspiracy to Steal Government Funds

A former case manager for the VA Supportive Services for Veteran Families (SSVF) grant program and a property manager pleaded guilty in the Northern District of Georgia to conspiracy to steal government funds. A VA OIG and Department of Housing and Urban Development (HUD) OIG investigation revealed that the defendants executed a scheme to steal SSVF and HUD-VA Supportive Housing (HUD-VASH) funds. From October 2014 through November 2015, the defendants received housing vouchers from the SSVF and HUD-VASH programs in support of housing homeless veterans. Instead of using these funds to make the appropriate rental payments on behalf of the veterans, the defendants kept the funds for themselves. As a result, 25 veterans were evicted from their residences. The total loss to VA is approximately $124,000.

Investigation Involving Benefits

Former Bank Manager Sentenced for Theft of Government Funds

A former bank manager in Las Vegas, Nevada, was sentenced to 30 months' imprisonment, three years' supervised release, and ordered to pay restitution of $1,196,075.95. Of the restitution, VA will receive approximately $757,900. A VA OIG and Social Security Administration OIG investigation revealed that the defendant used his position as a bank manager to access VA and social security benefit payments that were made to two deceased beneficiaries. The defendant then used the funds for personal expenses.

Investigations Involving Other Matters

Contractor Agrees to Pay $11 Million to Resolve Criminal and Civil Probes

A government contractor that provides electricity solutions for buildings and data centers entered into a nonprosecution and civil agreement with the Department of Justice Civil Division's Commercial Litigation Branch and the U.S. Attorney's Office for the District of Vermont. As part of the agreement, the contractor will pay $1.7 million in criminal forfeiture and admitted that its conduct constituted wire fraud. The contractor also agreed to pay $9.3 million to resolve False Claims Act and Anti-Kickback Statute liability for a former employee's scheme, which involved inflating estimates and assessing improper costs in proposals and overcharging federal agencies, including VA. This investigation was conducted by the VA OIG, Naval Criminal Investigative Service, Department of Agriculture OIG, Coast Guard Investigative Service, General Services Administration OIG, and the FBI.

Medical Device Manufacturer's Former Chief Executive Officer and Former Vice President of Sales Sentenced in Connection with Off-Label Marketing Scheme

A medical device manufacturer's former chief executive officer and former vice president of sales were sentenced in the District of Massachusetts for their roles in the marketing and distribution of a device for use outside of Food and Drug Administration approval. The former chief executive officer was sentenced to pay a criminal fine of $1 million, and the former vice president of sales was sentenced to pay a criminal fine of $500,000. The company previously entered into a global settlement with the government under which it agreed to pay a fine of $18 million. Of this amount, VA's portion of the settlement was $372,382. This investigation was conducted by the VA OIG, Defense Criminal Investigative Service, Food and Drug Administration Office of Criminal Investigations, and the FBI.

Administrative Investigation

False Statements and Concealment of Material Information by VA Information Technology Staff

The OIG investigated an allegation that certain VA employees had a conflict of interest regarding VA's establishment of a 2016 cooperative research and development agreement (CRADA). The CRADA contemplated VA sharing with a private company the health data of all veterans who had ever received VA health care. The CRADA was cancelled before any data disclosures were made. The OIG found no evidence of conflict of interest but substantiated that two VA employees who created the CRADA made multiple false statements to the approving official in advocating that he execute the CRADA while failing to disclose that VA privacy experts had raised significant unresolved concerns. The approving official relied on the information received from the two employees and was led to approve the CRADA under false pretenses. As prosecution was declined, investigators recommended VA determine what administrative action, if any, to take with respect to the two employees' conduct.

Audits and Reviews

VA Needs to Comply Fully with the Geospatial Data Act of 2018

The OIG conducted this audit to determine whether VA complied with the requirements of the "Covered Agency Responsibilities" section of the Geospatial Data Act of 2018. VA did not meet three of the 13 responsibilities. First, VA did not promote geospatial data activities, although the OIG found VA did not have the necessary criteria from the Federal Geographic Data Committee to develop and implement a strategy to comply with this requirement. Second, VA had not promoted geospatial data integration and, third, ensured that geospatial information was included on agency record schedules that have been approved by the National Archives and Records Administration, as required by the act. The OIG recommended that VA establish mandatory policies and responsibilities to promote the integration of geospatial data and establish a process that ensures geospatial data and activities are included on VA record schedules that have been approved by the National Archives and Records Administration.

Fiduciary Program: Some Incompetency Decisions Not Completed, Putting Those Beneficiaries' Funds at Risk

The OIG assessed the merits of an August 2019 hotline allegation that a deceased veteran's VA funds had been misused while he was living at a California nursing home. As part of this assessment, which is the subject of another report, the OIG discovered the Veterans Benefits Administration (VBA) had not finalized the veteran's incompetency proposal, which had been initiated three years before his death. This delay conflicts with VBA guidance that the decision be made, and a fiduciary appointed, within 141 days. The OIG expanded its review and found VBA had not finalized incompetency proposals for 221 beneficiaries from 2016 through 2019; statistical analysis of 55 of these showed nearly all had incomplete decisions—that is, had stalled. The OIG shared the 221 records with VBA so that it could determine whether further action is needed to ensure incompetency proposals are finalized.

Healthcare Inspections

Deficiencies in Inpatient Mental Health Care Coordination and Processes Prior to a Patient's Death by Suicide, Harry S. Truman Memorial Veterans' Hospital in Columbia, Missouri

The OIG reviewed a patient's mental health care prior to death by suicide. The OIG substantiated that the patient died by suicide within three days of discharge, and inpatient staff had initiated medication and provided discharge instructions that included suicide prevention materials. Inpatient staff did not include Vet Center staff in discharge planning and failed to complete the comprehensive suicide risk evaluation. Facility leaders did not establish a Mental Health Treatment Coordinator (MHTC) policy and staff did not assign an MHTC or report a positive suicide risk screening result in an issue brief. Veterans Integrated Service Network and National Center for Patient Safety leaders did not have knowledge of a memorandum of understanding that required Vet Center representation for shared patients during

Veterans Health Administration root cause analyses. The OIG made one recommendation to the under secretary for health and six recommendations to the facility director.

Deficiencies in Privileging a Urologist to Practice and Medication Management Processes at the VA Central Iowa Health Care System in Des Moines

The OIG conducted this healthcare inspection in response to a referral regarding a urologist who practiced, was privileged, and ordered controlled substances without a Drug Enforcement Administration (DEA) registration. The urologist practiced and was privileged without DEA credentials because facility leaders did not timely implement a directive requiring prescribers who order controlled substances to possess an individual DEA registration. Upon recognizing the urologist's noncompliance, facility leaders acted, and the urologist obtained the required DEA registration. The failure of the urologist to timely obtain a DEA registration was not related to clinical competency. The OIG was concerned, however, that the facility's operating room practice permitted surgeons to issue verbal orders for nonurgent medications without entering the medication orders into the Computerized Patient Record System. The practice bypassed quality controls and prevented pharmacists and controlled substance inspectors from reviewing medication orders. The OIG made five recommendations to the facility director.

Thoracic Surgery Quality of Care Issues and Facility Leaders' Response at the C.W. Bill Young VA Medical Center in Bay Pines, Florida

This healthcare inspection evaluated allegations against a thoracic surgeon regarding surgical complications including patient deaths, operative note misrepresentations, and the facility's inappropriate reporting of the surgeon's complication rate. A non-VA consultant identified quality of care concerns in 16 of 24 patient cases reviewed. Facility external management reviews found concerns with five patient cases, and in February 2019 the surgeon was reassigned to a nonclinical care setting. A VHA panel of cardiothoracic surgeons reviewed 22 of the 24 cases as well as additional cases. In December 2019, the panel determined that the surgeon delivered surgical care within quality expectations and the surgeon resumed patient care. The OIG made five recommendations related to a thoracic specialty leader, operative documentation, the National Surgery Office's assessments, and peer review processes to the under secretary for health. The OIG made five recommendations to the facility director related to operative documentation, professional communications, the Surgical Work Group, privileging, and institutional disclosures.

Medication Delivery Delays Prior to and During the COVID-19 Pandemic at the Manila Outpatient Clinic in Pasay City, Philippines

The OIG found that a patient experienced a medication delay in late 2019 due to a stock shortage. The OIG was unable to substantiate if a second patient experienced medication refill delays because the OIG could not determine when the refills were requested. Clinic leaders identified an increased pharmacy processing time in October 2019, and the chief of pharmacy services initiated an action plan that decreased the processing time. In March 2020, the President of the Philippines declared a COVID-19

emergency and implemented a quarantine that imposed travel limitations. As a result, four patients experienced medication delivery delays in March and April 2020. The OIG substantiated pharmacists could not dispense insulin to a patient as the clinic had no stock of the perishable medication after April 2020. The OIG determined none of these delays resulted in adverse clinical outcomes. The OIG made two recommendations related to pharmacy stock shortages and processing delays.

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